

AMENDED IN ASSEMBLY MARCH 25, 2008

CALIFORNIA LEGISLATURE—2007–08 REGULAR SESSION

**ASSEMBLY BILL**

**No. 2747**

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**Introduced by Assembly Members Berg and Levine**

February 22, 2008

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An act to add Part 1.8 (commencing with Section 442) to Division 1 of the Health and Safety Code, relating to end-of-life care.

LEGISLATIVE COUNSEL'S DIGEST

AB 2747, as amended, Berg. End-of-life care.

Existing law provides for the licensure and regulation of health facilities and hospices by the State Department of Public Health. Existing law provides for the regulation and licensing of physicians and surgeons by the Medical Board of California.

This bill would provide that when an attending physician makes a diagnosis that a patient has a terminal illness or makes a prognosis that a patient has less than one year to live, the health care provider shall provide the patient with the opportunity to receive information and counseling regarding legal end-of-life options, as specified, and provide for the referral or transfer of a patient if the patient's physician does not wish to comply with the patient's choice of end-of-life options.

Vote: majority. Appropriation: no. Fiscal committee: no.  
State-mandated local program: no.

*The people of the State of California do enact as follows:*

1     SECTION 1. The Legislature finds and declares all of the  
2     following:

1 (a) Palliative and hospice care are invaluable resources for  
2 terminally ill Californians in need of comfort and support at the  
3 end of life.

4 (b) Palliative care and conventional medical treatment should  
5 be thoroughly integrated rather than viewed as separate entities.

6 (c) Even though Californians with a prognosis of six months or  
7 less to live are eligible for hospice care, nearly two-thirds of them  
8 receive hospice services for less than one month.

9 (d) Many patients benefit from being referred to hospice care  
10 earlier, where they receive better pain *and symptom* management  
11 and have an improved quality of life.

12 (e) Significant information gaps *may* exist between health care  
13 providers and their patients on end-of-life options. ~~These gaps~~  
14 ~~include significant~~ *care options potentially leading to delays to,*  
15 *or lack of, referrals to hospice care for terminally ill and dying*  
16 *patients. The sharing of important information regarding specific*  
17 *treatment options in a timely manner by health care providers*  
18 ~~occurs unevenly. Missing information is a key component of quality~~  
19 *end-of-life care. Information that is helpful to patients and their*  
20 *families includes, but is not limited to, the availability of hospice*  
21 *care, the efficacy and potential side effects of continued curative*  
22 *treatment, and withholding or withdrawal of life sustaining*  
23 *treatments, voluntary stopping of eating and drinking, and palliative*  
24 *sedation.*

25 (f) Terminally ill and dying patients rely on their health care  
26 providers to give them timely and informative data. ~~Unfortunately,~~  
27 ~~research~~ *Research* shows a lack of communication between health  
28 care providers and their terminally ill ~~and dying patients. Problems~~  
29 ~~resulting from that lack of communication include~~ *patients can*  
30 *cause problems, including* poor availability of, ~~and health care~~  
31 ~~provider adherence to, patients' lack of clarity regarding,~~ advanced  
32 health care directives *and patients' end-of-life care preferences.*  
33 This lack of information and poor adherence to patient choices  
34 results in "bad deaths" that cause needless physical and  
35 psychological suffering to patients and their families.

36 (g) Those problems are complicated by social issues, such as  
37 ~~health care providers failing to inform patients about certain options~~  
38 ~~at the end of life on personal conscience grounds. A recent random~~  
39 ~~survey of 2000 United States physicians found that 17 percent of~~  
40 ~~them object to the practice of palliative sedation, defined as~~

1 administering sedation that leads to unconsciousness in dying  
2 patients. The survey also found that providers that object to these  
3 cultural and religious pressures for the providers, patients, and  
4 their family members. A recent survey found that providers that  
5 object to certain practices are less likely than others to believe  
6 they have an obligation to present all of the options to patients and  
7 refer patients to other providers, if necessary.

8 (h) Every medical school in California is required to include  
9 end-of-life care issues in its curriculum and every physician in  
10 California is required to complete continuing education courses  
11 in end-of-life care.

12 (i) Palliative care is not a one-size-fits-all approach. Patients  
13 have a range of diseases and respond differently to treatment  
14 options. A key benefit of palliative care is that it customizes  
15 treatment to meet the needs of each individual person.

16 (h)

17 (j) Informed patient choices will help dying terminally ill  
18 patients and their families cope with one of life's most challenging  
19 situations.

20 SEC. 2. Part 1.8 (commencing with Section 442) is added to  
21 Division 1 of the Health and Safety Code, to read:

22  
23 PART 1.8. END-OF-LIFE CARE  
24

25 442. For the purposes of this part, the following definitions  
26 shall apply:

27 (a) "Curative treatment" means treatment intended to cure or  
28 alleviate symptoms of a given disease or condition.

29 (a)

30 (b) "Hospice" means a specialized form of interdisciplinary  
31 health care that is designed to provide palliative care, alleviate the  
32 physical, emotional, social, and spiritual discomforts of an  
33 individual who is experiencing the last phases of life due to the  
34 existence of a terminal disease, and provide supportive care to the  
35 primary caregiver and the family of the hospice patient, and that  
36 meets all of the criteria specified in subdivision (b) of Section  
37 1746.

38 (b)

39 (c) "Palliative care" means medical treatment, interdisciplinary  
40 care, or consultation provided to a patient or family members, or

1 both, that has as its primary purpose the prevention of, or relief  
2 from, suffering and the enhancement of the quality of life, rather  
3 than treatment aimed at investigation and intervention for the  
4 purpose of cure or prolongation of life as described in subdivision  
5 (b) of Section 1339.31.

6 ~~(e)~~

7 (d) “Palliative sedation” means the use of sedative medications  
8 to relieve extreme suffering by making the patient unaware and  
9 unconscious, *while artificial food and hydration are withheld*,  
10 during the progression of the disease leading to the death of the  
11 patient.

12 ~~(d)~~

13 (e) “Refusal or withdrawal of life sustaining treatment” means  
14 forgoing treatment or medical procedures that replace or support  
15 an essential bodily function, including, but not limited to,  
16 cardiopulmonary resuscitation, mechanical ventilation, artificial  
17 nutrition and hydration, dialysis, and any other treatment or  
18 discontinuing any or all of those treatments after they have been  
19 used for a reasonable time.

20 ~~(e)~~

21 (f) “Voluntary stopping of eating and drinking” or “VSED”  
22 means the voluntary refusal of a patient to eat and drink in order  
23 to alleviate his or her suffering, and includes the withholding or  
24 withdrawal of life-sustaining treatment at the request of the patient.

25 442.5. When an attending physician makes a diagnosis that a  
26 patient has a terminal illness or makes a prognosis that a patient  
27 has less than one year to live, the physician, or in the case of a  
28 patient in a health facility, as defined in Section 1250, the health  
29 facility, shall provide the patient with the opportunity to receive  
30 *comprehensive* information and counseling regarding ~~all~~ legal  
31 end-of-life *care* options. ~~If~~

32 (a) *If* the patient indicates a desire to receive the information  
33 and counseling, the information shall include, but not be limited  
34 to, ~~all of~~ the following:

35 ~~(a) (1) Written materials that list all available medical options~~  
36 ~~at the end of life, including, but not limited to, all of the following:~~

37 ~~(A)~~

38 (1) Hospice care at home or in a health care setting.

39 ~~(B)~~

1 (2) A prognosis with and without the continuation of curative  
2 treatment.

3 ~~(C)~~

4 (3) The *patient's right to* refusal or withdrawal from  
5 life-sustaining treatment.

6 ~~(D) VSED and palliative sedation.~~

7 ~~(2) The written materials described in paragraph (1) shall~~  
8 ~~provide detailed explanations of the patient's options, and shall~~  
9 ~~include a list of resources that are available to the patient for further~~  
10 ~~research on options.~~

11 (4) *The patient's right to continue to pursue curative treatment*  
12 *while receiving palliative care.*

13 (5) *The patient's right to comprehensive pain and symptom*  
14 *management at the end of life, including, but not limited to,*  
15 *adequate pain medication, treatment of nausea, palliative*  
16 *chemotherapy, relief of shortness of breath and fatigue, VSED,*  
17 *and palliative sedation.*

18 (b) *The information described in subdivision (a) may, but is not*  
19 *required to be, in writing.*

20 ~~(b)~~

21 (c) Counseling ~~that shall~~ *may* include, but not be limited to,  
22 discussions about the outcomes on the patient and his or her family,  
23 based on the interest of the patient.

24 442.7. If a physician does not wish to comply with his or her  
25 patient's choice of end-of-life options, the health care provider  
26 shall do both of the following:

27 (a) Refer or transfer a patient to an alternative health care  
28 provider.

29 (b) Provide the patient with information on procedures to  
30 transfer to an alternative health care provider.